Maternity and Paediatric Quality and Safety report: data to December 2014

1. Glossary

BBA	Born Before Arrival
BSUH	Brighton and Sussex University Hospitals NHS Trust
CBC	Crowborough Birthing Centre
CCG	Clinical Commissioning Group
CTG	Cardiotocographs
CQ	Conquest Hospital
EDGH	Eastbourne District General Hospital
EMU	Eastbourne Midwifery Unit
ESHT	East Sussex Healthcare NHS Trust
HOSC	East Sussex Health Overview and Scrutiny Committee
HIE	Hypoxic Ischaemic Encephalopathy
LSCS	Lower Segment Caesarean Section
MLU	Midwifery Led Unit
MSW	Maternity Support Worker
MTW	Maidstone and Tunbridge Wells NHS Trust
NICU	Neonatal Intensive Care Unit
RCOG	Royal College of Obstetricians and Gynaecologists
RSCH	Royal Sussex County Hospital
NHS	National Health Service
SCBU	Special Care Baby Unit
SI	Serious Incident
SSPAU	Short Stay Paediatric Assessment Units
TWH	Tunbridge Wells Hospital

2. Summary

2.1 Measurable safety improvements demonstrated within Trust Obstetric and Maternity services following the temporary reconfiguration of services in May 2013 and the subsequent decision post consultation have been sustained.

2.2 The Trust has reported significantly fewer maternity related Serious Incidents (SIs) following the reconfiguration of 07 May 2013 and similar incidents are not recurring.

2.3 The Trust has systems in place to undertake analysis of all incidents, and to feedback learning to all relevant staff. The quality of Serious Incident reporting has improved which provides further assurance around the Trust's ability to manage and implement learning.

2.4 The Trust has sustained a higher level of consultant presence on the labour wards (was 48hrs pre-configuration and is now 72hrs). This has translated into increased consultant involvement in decision making, increased consultant performance of operative obstetric procedures and direct supervision of junior doctors performing these procedures.

2.5 Safety has improved post reconfiguration as middle grade medical staff are now able to call upon the support and direction of the Consultant medical

body in a timely manner. This is a result of the fact that these staff groups are now working on the same site. There is now a more advanced support structure for middle grade medical staff resulting in better outcomes for mothers and babies.

2.6 Reconfiguration has led to a significant decrease in the use of locum medical staff who are unfamiliar with Trust protocols, procedures and the physical environment of the maternity wards. This has led to fewer incidents, improved middle grade medical decision making and contributed to a safer environment for mothers and babies.

2.7 Maternity staffing issues such as short term sickness have occasionally affected the operational effectiveness of the midwifery led units leading to diverts and closure. Following reconfiguration the Trust is better placed to manage issues as they arise, redeploy staff and utilise assets more effectively. The Trust has demonstrated that they are able to achieve this in a safe, considered and systematic fashion.

2.8 The Trust is taking active steps to address midwifery staffing issues and has demonstrated improvements following reconfiguration in managing staff sickness.

2.9 One of the key improvements relating to maternity staffing levels is that post reconfiguration the Trust is no longer reliant upon the use of agency midwives. There is a stronger cadre of midwifery staff who are familiar with team processes, Trust protocols, guidelines and the physical environment which is crucial for providing a safe and quality service for mothers and babies.

2.10 The Trust continues to monitor both scheduled and unscheduled Lower Segment Caesarean Section (LSCS) rates and is not exceeding the national goal of 23% when measured over the year. Following the reconfiguration the middle grade medical staff decision making process and Consultant oversight has improved in relation to complications arising from Caesarean section.

2.11 The Trust continues to report babies Born Before Arrival (BBAs) when they occur. There has been no impact on mothers living in the Eastbourne area with regard to BBAs as a result of the reconfiguration. There continues to be an increase of BBAs reported in the Hastings and Rother area for mothers booked to give birth at the Conquest.

2.12 For those mothers who have experienced a BBA the Trust has confirmed that mothers and babies are triaged by a Community Midwife and if clinically indicated are advised to be transferred to the relevant maternity unit. The overwhelming majority of mothers who experienced a BBA underwent a homebirth and chose not to be admitted to hospital post-delivery. There have been no Serious Incidents post 07 May 2013 as a result of a BBA.

2.13 Patient experience continues to be reviewed and monitored by both the Trust and Commissioners in relation to both Maternity and Paediatric services.

Themes and trends resulting from patient feedback are reviewed and incorporated into service provision. Analysis of patient feedback indicates no complaints related directly to the quality and safety of the maternity and paediatric configuration. This area continues to be monitored by both the Trust and Commissioners.

3. Monitoring the impact of the new configuration of services

The driver for the temporary and subsequent permanent single siting of obstetric and inpatient paediatric services was to ensure sustainably safe services. The CCGs have continued to monitor the quality and safety of the services currently being delivered, with an enhanced focus on key indicators that are most likely to be impacted by a change in service reconfiguration.

3.1 It should be noted that these form part of a wider set of indicators that continue to be monitored as part of the CCGs' clinical quality review meetings, and reported to the CCG Governing Bodies. ESHT also reports regularly to their Trust Board.

3.2 This report provides information against each of the key indicators agreed with the HOSC in January 2015.

Maternity Services

4. Serious incidents (SIs)

Position since 07 May 2013: **IMPROVED**

4.1 SIs are reported via the Trust DATIX system. All reported SIs are subjected to a full Root Cause Analysis (RCA). The Trust undertakes a review of contributory factors which have led to the occurrence of Serious Incidents.

4.2 The reduction in Serious Incidents following reconfiguration has been sustained

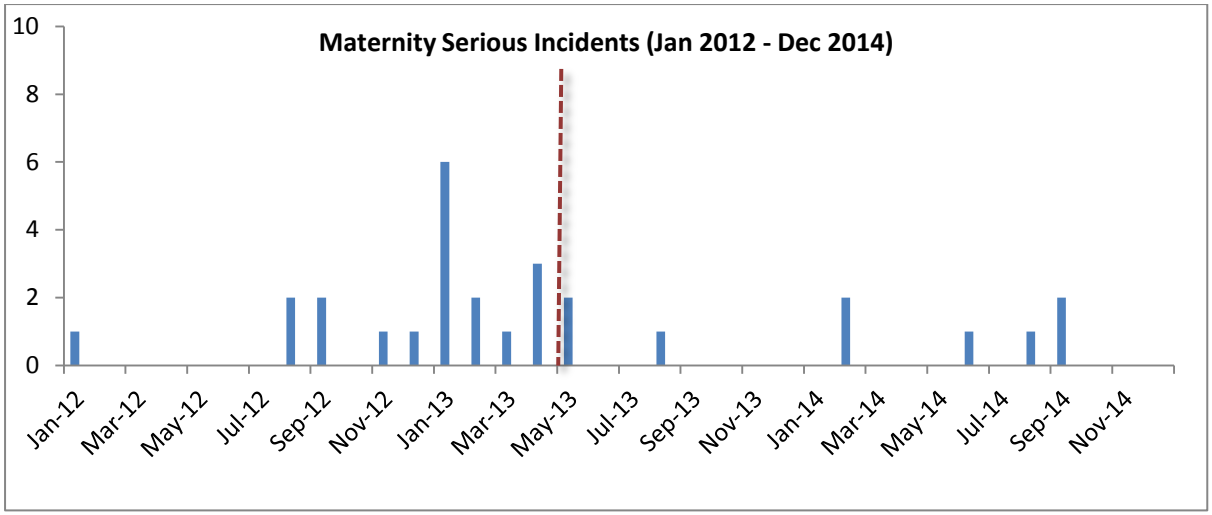
4.3 There have been no maternal deaths reported by the Trust since the reconfiguration of 07 May 2013.

4.4 There has been a decrease in babies with Hypoxic Ischaemic Encephalopathy (HIE) and the maintenance of the traditionally low perinatal mortality rate.

4.5 Prior to reconfiguration a trend had been identified as a contributing factor to Serious Incidents occurring relating to the lack of substantive medical and midwifery staff. This led to an over reliance on middle grade locum doctors and agency midwives. This position has improved following reconfiguration and continues to be sustained.

4.6 Following reconfiguration there has been no key trends identified relating to medical and midwifery staffing levels

4.7 Graph 1: Maternity Serious Incidents (Jan 2012 - Dec 2014)



4.8 Table 1: Serious Incidents by month (Jan 2012 – December 2014)

January 2012 – December 2012												TOTAL
J	F	M	A	M	J	J	A	S	O	N	D	7
1	**0**	**0**	**0**	**0**	**0**	**0**	**2**	**2**	**0**	**1**	**1**	

January 2013 – December 2013												TOTAL
J	F	M	A	M*	J	J	A	S	O	N	D	12 (3*)
6	2	1	3	2	0	0	1	0	0	0	0	

January 2014 – December 2014												TOTAL
J	F	M	A	M	J	J	A	S	O	N	D	6
0	2	0	0	0	1	0	1	2	0	0	0	

* *3 reported SIs from 07 May 2013 (May to Dec 2013)*

5. Lessons Learned

5.1 Learning to prevent Serious Incidents continues to be embedded within the Trust. Some examples of learning by theme are cited below:

Staffing

5.2 All incidents are reviewed and there have been no trends relating to medical staff and supervision following reconfiguration

5.3 Consultant presence on labour ward is sustained at 72 hours per week

Training

5.4 All staff undertake either K2 or the Royal College of Obstetricians and Gynaecologists (RCOG) CTG training package and this training is monitored

5.5 Additional training has been put in place for the paediatricians to support them in intubation and resuscitation of babies and discuss the details regarding preparation of babies who are to be retrieved to a Neo-natal Intensive Care Unit (NICU)

5.6 CTG training for all midwifery and medical staff is provided on a monthly basis. There is a comprehensive teaching programme for all staff who attend this session.

5.7 Monitoring of staff in terms of mandatory and additional updating is done by both midwifery supervision for midwives and by the annual appraisal for all staff

Root Cause Analysis (RCA)

5.8 Completed RCAs of Serious Incidents continue to be sent to all those involved in a case and shared with doctors and midwives at training sessions

5.9 RCAs continue to be sent to all midwifery matrons to share with their teams and discuss the learning points and recommendations

5.10 Multidisciplinary incident review meeting to discuss incidents from the previous 48-72 hours continues. This helps to ensure that if an incident is deemed to be serious it can be escalated promptly.

6. C-section rates (total, scheduled and unscheduled)[1]

Position since 07 May 2013: **NEUTRAL**

6.1 The Trust actively monitors C- Section activity in line with national guidance. The graphs below indicate the Trusts position against the:

- total C-Section rate
- scheduled C- Section rate
- unscheduled C- Section rate

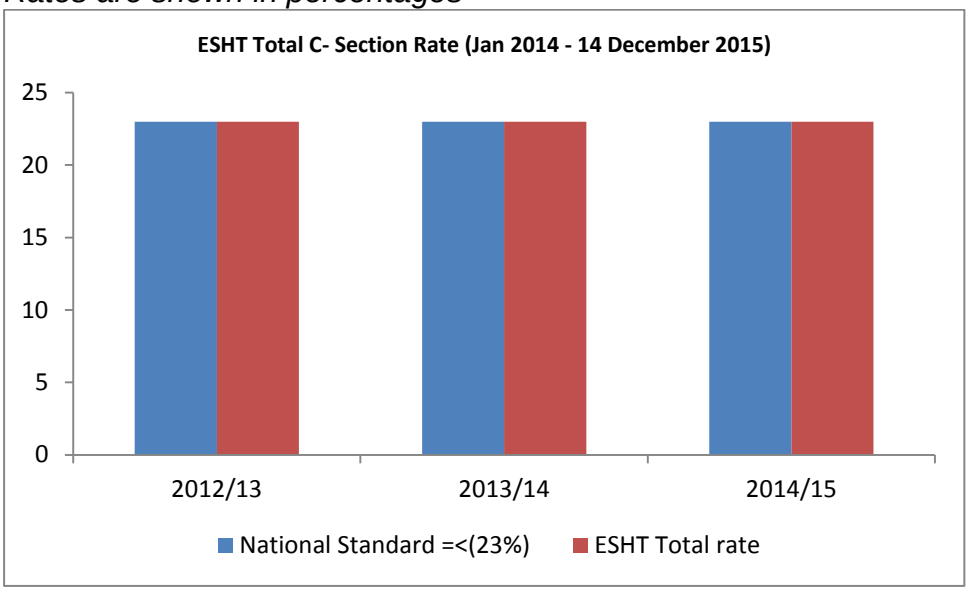
6.2 In 2012/13 and 2013/14 all three rates of total, scheduled and unscheduled were achieved at the level of the required national target standard

6.3 So far in 2014/15 for which the data is only complete up to and including November 2014 the planned rate is down by 1% and the emergency rate is up by 1%

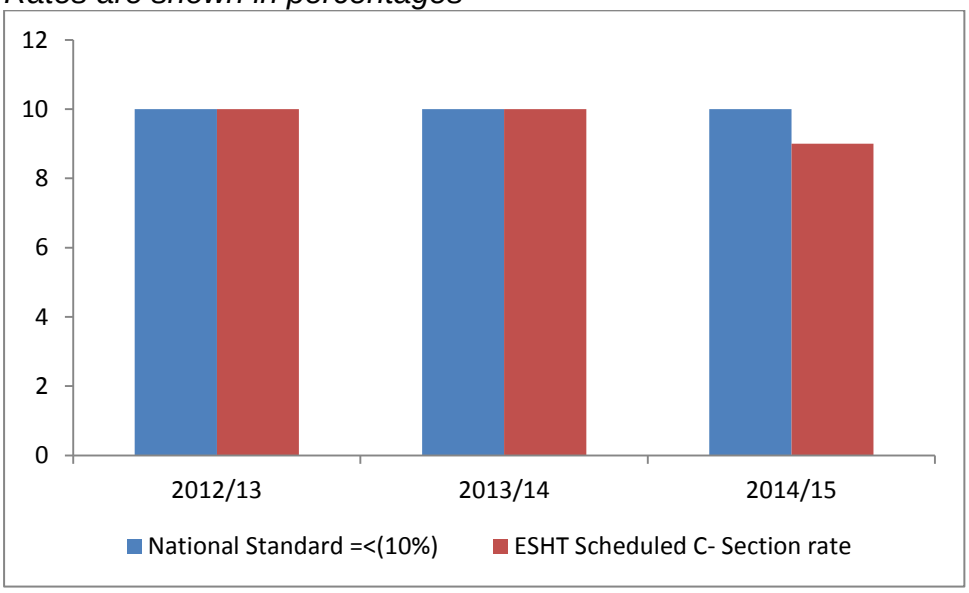
6.4 Despite an upward trend in LSCS rates throughout the country and also in ESHT prior to reconfiguration, ESHT has maintained a steady LSCS rate and within national goals of 23%. This rate has not been impacted by the reconfiguration.

[1] Source: Euroking extracts, January 2012 – 14 December 2014

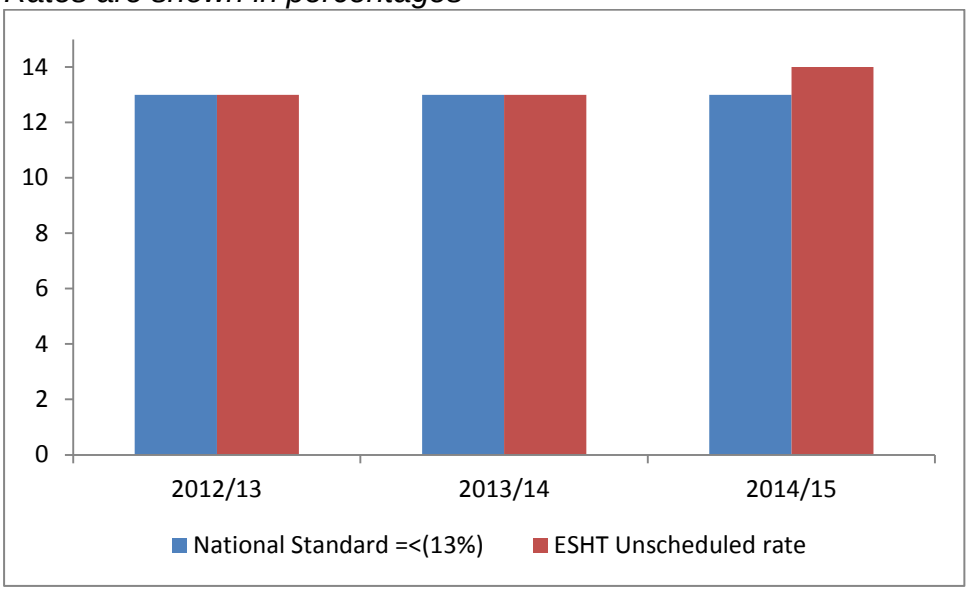
Graph 2: ESHT Total C- Section Rate (Jan 2012 - 14 December 2015)
Rates are shown in percentages



Graph 3: ESHT Scheduled C- Section rate (Jan 2012 - 14 December 2015)
Rates are shown in percentages



Graph 4: ESHT Unscheduled C- Section rate (Jan 2012 - 14 Dec 2015)
Rates are shown in percentages



7. Babies born before arrival (BBAs)[2]

Position since 07 May 2013: **NEUTRAL**

7.1 There is no nationally agreed definition for a baby born before arrival. For the purpose of this report the BBA definition refers to those babies born before the arrival of a midwife; as a result, even if a paramedic is in attendance it will still be a BBA. It should be noted this can give rise to slightly different figures being reported.

7.2 To address this the Trust has taken action to ensure that BBAs are reported in a consistent manner with sub categories of birth (for example, Born in transit in a car and Born in transit in an Ambulance), together with a conclusion as to whether the BBA was either “avoidable” or “unavoidable”. This will be fully implemented from 01 April 2015.

7.3 Following a BBA the mother and baby are reviewed by a Community Midwife. If clinically indicated both mother and baby will be transferred to the most appropriate maternity unit otherwise they remain at home.

7.4 The information below is the latest iteration of BBAs up until the end of December 2014. This information may differ slightly from the data supplied in the previous Quality update to the HOSC for the reasons cited above.

7.5 The **key headlines** in relation to BBAs are:

- No adverse outcomes for mothers or babies have been reported in relation to BBAs (some babies will have been transferred into maternity

[2] Source: ESHT Head of Midwifery records based upon Euroking extracts and DATIX entries January 2012 – 14 December 2014

units for observation checks or "warming up" in line with standard practice)

- The two key themes in relation to BBAs occurring include births taking place quicker than expected and expectant mothers not seeking advice from a midwife in good time.

- Following review the Trust has not identified proximity to a birthing unit as a significant factor in reported BBAs taking place

7.6 Table 2: Women who experienced a BBA and were booked to birth at the Crowborough Birthing Centre

	J	F	M	A	M	J	J	A	S	O	N	D	Total
2012	0	0	0	0	0	0	0	0	0	2	0	2	**4**
2013	0	1	0	1	0	0	1	1	1	0	0	0	**5**
2014	0	0	1	0	0	1	0	0	1	1	0	0	**4**

Key points:

- No adverse outcomes were seen for any of these babies

- In 2012, three woman chose to remain at home post-delivery and one was transferred into CBC

- In 2013 all six women chose to remain at home post delivery

- In 2014 two women chose to remain at home post-delivery, one was transferred into CBC as was born in the car park outside CBC and three were transferred to Tunbridge Wells Hospital

7.7 Table 3: Women who experienced a BBA and were booked for birth at the EDGH/EMU

	J	F	M	A	M	J	J	A	S	O	N	D	Total
2012	2	0	1	0	4	4	0	1	0	2	2	2	**18**
2013	1	1	1	0	1	1	1	0	1	0	1	0	**8**
2014	0	3	0	1	3	0	1	0	1	3	0	3	**15**

Key points:

- No adverse outcomes were seen for any of these babies

- These figures refer mostly to women with an Eastbourne, Hailsham and Seaford (EHS) CCG postcode

- In 2012, thirteen women chose to remain at home post-delivery of which two were delivered by paramedics, one born in hospital corridor so transferred into the ward, two transferred to the Eastbourne District General Hospital (EDGH), one baby transferred to the Special Care Baby Unit (SCBU) and one baby born in transit in hospital with a paramedic

- In 2013, five chose to remain at remain at home post-delivery, two were transferred into EDGH and one was transferred to SCBU as pre term. All women were booked to give birth at the EDGH/EMU.

- In 2014, fourteen remained at home and one was transferred to Brighton from Seaford due to maternal condition.

7.8 Table 4: Women who experienced a BBA and were booked to give birth at the Conquest Hospital

	J	F	M	A	M	J	J	A	S	O	N	D	Total
2012	1	1	2	1	3	0	3	1	2	1	1	0	**16**
2013	3	1	0	4	2	3	1	1	1	1	1	2	**20**
2014	1	1	2	3	2	2	5	1	3	0	2	4	**26**

Key points:

- No adverse outcomes were seen for any of these babies

- The majority of mothers who experienced BBAs continue to reside in the Hastings, Bexhill, St Leonards and Robertsbridge areas.

- In 2012, eight women chose to remain at home post-delivery, five transferred to Conquest, two delivered in the car so transferred into Conquest and one baby went to the SCBU

- In 2013, five women chose to remain at home post-delivery, seven were transferred into Conquest, two babies went to SCBU and six babies were born in transit – three in cars, one on the door step as leaving for the hospital and two in ambulances delivered by paramedics. One out of area when William Harvey Ashford was on divert and 1 en route to Conquest

- In 2013, four out of the twenty women who experienced a BBA were from the EHS CCG area (postcode areas include Hailsham and Eastbourne). These BBAs took place from the 10 May 2013.

- In 2014, thirteen women chose to remain at home post-delivery, nine transferred into the Conquest, four mothers gave birth in transit (three in the ambulance and one in a car en route to Conquest)

- In 2014, 3 out of the twenty six women who experienced a BBA were from the EHS CCG area (postcode areas include Hailsham and Eastbourne)

8. Midwife to birth ratio

Position since 07 May 2013: **NEUTRAL**

8.1 The national standard set by Birthrate Plus is to have a ratio of 1:29 or lower and the locally agreed indicator is 1:30.

8.2 The midwife to birth ratio is measured across all sites where the Trust provides maternity services.

8.3 When broken down into site specific data, midwife to birth ratio is significantly different. This measure is similar for all Trusts that provide services across multiple MLU sites

8.4 The midwife to birth ratio will always be higher at an MLU which has to be staffed 24 hours a day to respond to intrapartum activity whenever it happens but with fewer births than at the acute site (this means the staffing levels at MLUS will be lower due to the reduced number of births)

8.5 At each of the MLUs, staff not only provide intrapartum care but also antenatal and postnatal care

8.6 At the Conquest the ratio is higher and is a consequence of staffing two MLU's with much lower birthing activity

8.7 Staffing is reviewed daily to ensure the safety of women and babies

8.8 Table 5: Midwife to birth ratio, 2012 – 2014 (National Standard – 1:29)

	2012	2013	2014
Trust Level (Average)	**1:32**	**1:27**	**1:30**
EDGH*	1:32	1:20	1:18
CBC	1:18	1:18	1:15
Conquest	1:38	1:33	1:38

** EMU from 07 May 2013*

9. Diverts and site closures

Position since 07 May 2013: **IMPROVED**

9.1 From 07 May 2013 the Conquest has not closed or gone onto divert up to and including February 2015.

9.2 The reconfiguration has ensured a sustainable, safe obstetric-led service.

9.3 In 2012 and early 2013, divert procedures were instigated on over seventy occasions between the EDGH and Conquest for the reasons related to capacity, medical or midwifery staffing.

9.4 Following reconfiguration, occasional closures and diverts continue to occur in the MLUs. A unit can be closed for a small amount of time and often no women are affected.

Table 6: Closures and Diverts (2013)[3]

2013	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
CBC closed	0	0	0	1	1	3*		
No. women diverted				0	0	0		
Where to				CQ	CQ	CQ		

Key Points 2013

- All diverts were overnight except * 31/10 07.30 until 4/11/13 10.00 CBC on divert – **no women diverted**

- During these diverts the Midwife and Maternity Support Worker (MSW) on duty were re-located to Conquest.

Table 7: Closures and Diverts (2014)[4]

2014	J	F	M	A	M	J	J	A	S	O	N	D
CBC closed	1		2		2	1	2	1(*)	2		1	6($)
EMU closed	0					1			1	1		3
No. women diverted	0		0		1	0	1	3	1 from EMU	1	0	2 from CBC
Where to					EMU		TWH	EMU PRH TWH	CQ			TWH x2

Key points 2014

- All diverts were overnight except (*) 22/08 – 25/08/14 and ($) CBC diverted during the day due to staffing issues and one woman diverted to Tunbridge Wells Hospital (TWH) – **very few women (9) diverted**

- During these diverts the Midwife and Maternity Support Worker (MSW) on duty were re-located to Conquest

10. Transfers from MLUs to Obstetric Units

Position since 07 May 2013: **NEUTRAL**

10.1 No babies transferred from an MLU to an Obstetric Unit have been born en route.

10.2 The average transfer time meets the agreed standard (from making the decision to handover, to the receiving unit within our area) of 80 minutes.

10.3 The Trust has confirmed that all local transfers for first births continue to be achieved within the national average of 36%[5] .

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[3] Source: Euroking extracts, January 2012 – 14 December 2014
[4] Source: Euroking extracts, January 2012 – 14 December 2014

11. Maternity Staffing[6]

Position since 07 May 2013: **IMPROVED**

11.1 The quality of midwifery staffing has improved with significantly less reliance on agency midwifery staffing compared with pre – 07 May 2014.

11.2 Midwife maternity leave and long term sickness and vacancies are reducing. Existing mitigations stay in place with regular bank and agency midwives who are familiar with Trust protocols and processes and ad hoc diverts enacted from the MLU's as required. Midwifery recruitment is on-going and the Head of Midwifery is investigating overseas recruitment from Europe as required.

11.3 The Trust has undertaken an analysis of midwifery staffing levels from the perspective of midwives in post against establishment for 2014. This has been undertaken for the Conquest, EMU and CBC sites. The Trust has provided commissioners with assurance that whilst the maternity led units are not always staffed to their full establishment rate there is sufficient flex within the system to maintain a safe service at the Conquest hospital by moving midwifery staff around the system as required.

12. Obstetric Medical Staffing

Position since 07 May 2013: **IMPROVED**

12.1 The Trust has demonstrated a sustained higher level of consultant presence on the labour wards than when the previous configuration was in place (was 48hrs and is now 72hrs). This has translated into increased consultant involvement in decision making, increased consultant performance of operative obstetric procedures and direct supervision of junior doctors performing these procedures. The elective caesarean lists now have a specific consultant supervisor separate from the labour ward consultant.

12.2 Safety has improved as a result of the reconfiguration as middle grade medical staff are now able to call upon the support and direction of the Consultant medical body after 1700 for direct supervision on site. This means that there is now a more advanced support structure for middle grade medical staff which has resulted in better outcomes for mothers and babies.

12.3 In line with the maternity staffing experience the reconfiguration has led to a decreased use of locum medical staff and the use of locum staff who are unfamiliar with Trust protocols, procedures and the physical environment of the maternity wards has reduced significantly.

12.4 Following reconfiguration any absence or sickness has been covered by doctors in substantive posts, in a minority of instances external known

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[5] Source: Telephone conversation between CCG Quality Manager and Trust Head of Midwifery, 17 March 2015

[6] Source: Email from ESHT Head of Midwifery to East Sussex CCGs, 11 March 2015 and Head of Midwifery Establishment vs Post figures, 11 March 2015

locums have been utilised in low-risk clinical areas with adequate supervision.

12.5 There have been less serious incidents being reported as a result with improved middle grade medical decision making and contributed to a safer environment for mothers and babies.

13. Maternity Patient Feedback[7]

Position since 07 May 2013: **IMPROVED**

13.1 The operational quality and safety forum for ensuring the review of key quality areas with the Trust is the monthly Clinical Quality Review Group where Maternity services are a regular agenda item. This meeting also reviews aspects of patient experience in relation to Trust services, including Maternity (which included the Friends and Family Test).

Key points:

- The Trust is also performing well in relation to feedback from the Friends and Family Test and has consistently scored above the minimum standard.

- Patient feedback from the Maternity Friends and Family Test include staff attitude on the antenatal wards, more affordable antenatal classes, requests for showers in baths, a request to keep the CBC open, a request to move obstetric services back to the EDGH, discharge planning and general staff attitude.

- The number of complaints have reduced post reconfiguration. The same themes persist regarding standards of care and provision of services, which reflect national trends.

14. Births by site

14.1 Information relating to the number of births by site does not relate to the quality and safety of the service but does provide activity information as requested by the HOSC

14.2 The overall birth rate within ESHT has decreased by 7.1% in 2013 and a further 8.6% in 2014. This is in line with anticipated trajectories following reconfiguration.

14.3 Activity at the Conquest has increased following the single siting happened on 07 May 2013. Eastbourne data cannot be compared as EMU data has only been collected for one full calendar year.

Following the service reconfiguration of 07 May 2013 the numbers of births at the EDGH has decreased with clinically screened “high risk” pregnancies

[7] Source: Email from ESHT Head of Midwifery to East Sussex CCGs, 25 February 2015

being redirected to the Conquest as the safety of mothers and babies is the first concern for the Trust.

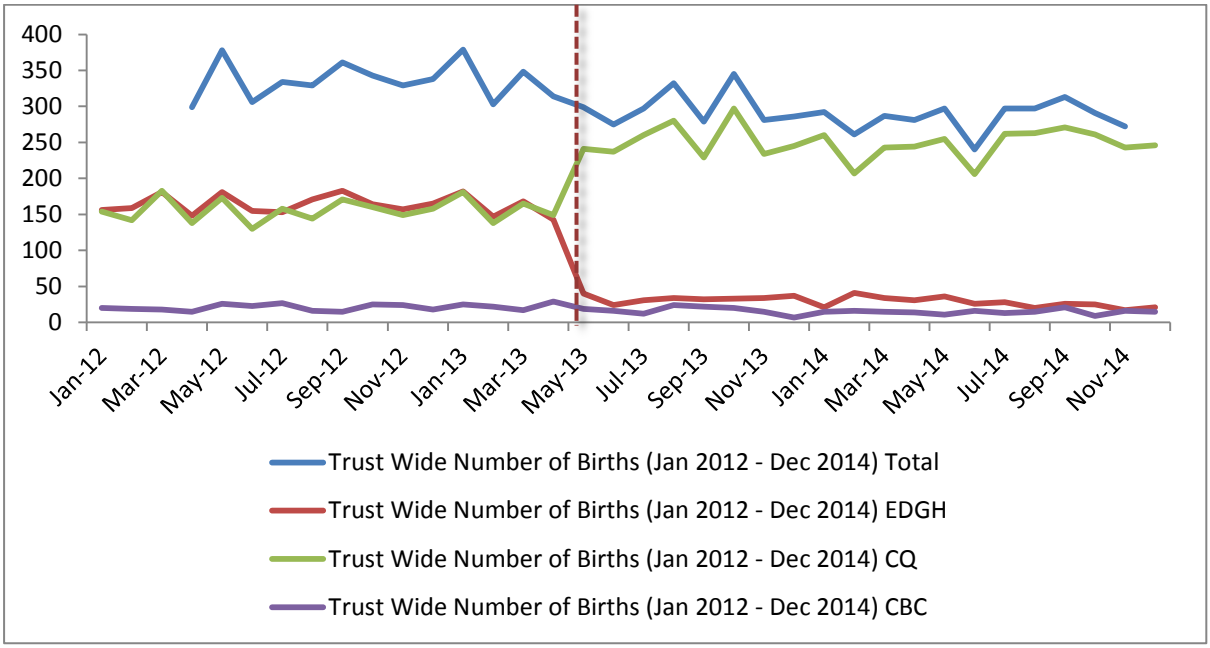
14.4 The tables below indicate the number of births by site by year for each of the three East Sussex maternity units in line with a previous request from the East Sussex HOSC.

Table 8: Births by site by year

Site	2012	2013	2014
Conquest	1860	2656	2961
Eastbourne *	1973	905	326
Crowborough Birthing Centre (CBC)	246	228	176
Total of births at ESHT	4079	3789	3463

* EMU only from 07 May 2013

Graph 5: Trust wide number of births by month (Jan 2012 - Dec 2014)



Paediatric Services

15. Paediatric Staffing[8]

Position since 07 May 2013: **IMPROVED**

[8] Source: Email from Head of Nursing, Women's and Children Clinical Unit to Children, Young People and Maternity Services Joint Commissioning Manager, 25 February 2015

15.1 The Trust has confirmed that the inpatient paediatric nursing staffing levels are in line with the required establishment.

15.2 A number of staff members made the personal decision to move to Kipling Ward at the Conquest Hospital permanently whilst others decided to work across both sites. This option has enhanced working at the Conquest Short Stay Paediatric Unit (SSPAU).

15.3 An additional clinical nurse educator role has been secured to support workforce, training and development.

15.4 Four newly qualified staff nurses joined Kipling ward in September 2014.

15.5 A healthcare assistant is currently seconded to undertake her nurse training demonstrating that the Trust is "growing their own" staff and looking forward to succession planning.

15.6 In relation to Neonatology, a Band 6 sister now has protected time in a clinical nurse educator role for one day per week to support workforce, training and development on the unit. The Trust has reported that the workforce is stable with one member of staff currently on maternity leave. A newly qualified nurse will join the team in June 2014 after an internal rotation.

16. Paediatric Serious Incidents
Position since 07 May 2013: **NEUTRAL**

16.1 There have been zero paediatric Serious Incidents reported to Commissioners as a result of the reconfiguration since the 07 May 2013 to the time of writing this report.

16.2 There has been one paediatric Serious Incident reported since 07 May 2013 to the time of writing this report which did not relate to the safety and quality of paediatric services

17. Summary of Paediatric Service Feedback[9]
Position since 07 May 2013: **NEUTRAL**

17.1 There was an initial increase in complaints following reconfiguration related to the provision of services however these have significantly decreased during 2014 (from eighteen to nine for period 07 May 2013 - 30 September 2013 and 07 May 2014 - 30 September 2014).

17.2 These complaints relate predominately to provision of services, communication, standards of care and staff attitude

[9] Source: Email from Head of Nursing, Women's and Children Clinical Unit to Children, Young People and Maternity Services Joint Commissioning Manager, 24 February 2015

18. Paediatric Transfers from EDGH to Conquest Hospital[10]

18.1 Information relating to the number of admissions by site does not relate to the quality and safety of the service but does provide activity information as requested by the HOSC.

18.2 The Trust have confirmed that between January 2014 and December 2014 a total of 6935 paediatric admissions took place at Trust level

18.3 Of this number 4608 were admitted to the Conquest Hospital and 2327 were admitted to the EDGH.

18.4 Of the 2327 EDGH total, 267 transfers took place from the EDGH SSPAU to the Conquest Hospital. This averages a monthly total of 22 and is in line with information previously reported to the HOSC where the average reported was 20.

19. Conclusion

19.1 **T**he configuration agreed by the three CCG Governing Bodies in East Sussex, and supported by the HOSC, has resulted in sustained improvements in safety and quality for maternity and paediatric services.

19.2 The CCGs and the Trust continue to monitor the safety and quality of all services as part of on-going organisational business.

March 2015

-end-

[10] Source: ESHT Business Intelligence Paediatric Activity (December 2013 to December 2014), 12 February 2015